

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06083

CERTIFICATE OF DEATH

6093

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Faithner</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Faithner</i>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <i>DAISY MARIE BOWLING</i>		(Month) (Day) (Year) <i>June 6 1956</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>July 15 1885</i>	9. AGE last birthday <i>70</i> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Charles Co</i>
13. FATHER'S NAME <i>Albert Simpson</i>		14. MOTHER'S MAIDEN NAME <i>Ida Moran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <i>Mrs Ernest Cooksey Dentsville</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular Anomorph</i>			<i>1/2 hr.</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>hypertension</i>			<i>10 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6-6</i> , 19 <i>56</i> , to <i>6-6</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6-6</i> , 19 <i>56</i> , and that death occurred at <i>11:45P</i> , from the causes and on the date stated above.			
SIGNATURE <i>F. M. Johnson</i>		DATE SIGNED <i>LA PLATA, md 6-7-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		24. REC'D BY REGISTRAR <i>Julia H. Paresy</i>	
DATE <i>6/9/56</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Inc. Leplata Md.</i>	

CERTIFICATE OF DEATH

6003

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

BUREAU V. 2

JUN 19 1936

RECEIVED

RECEIVED

RECEIVED
JUN 19 1936
BUREAU V. 2

6094

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Md.				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Maryland				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Anne Brown				4. DATE OF DEATH June 5 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1956	
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24		IF UNDER 24 HRS. Hours 24 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Brown				14. MOTHER'S MAIDEN NAME Myrtle Bearbena Duckett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Myrtle Bearbena Duckett Brown			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (Birth Weight 4lbs.) DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Father refused hospitalization for infant at time of birth							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William J. Kurz				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William J. Kurz				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/56		22c. NAME OF CEMETERY OR CREMATORY Home Plot		22d. LOCATION (City, town, or county) (State) Bryantown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. Brown, Waldorf, Md				24a. REC'D BY REGISTRAR DATE 6/6/56		24b. REGISTRAR'S SIGNATURE Julia H. Carey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
DATE OF EXAMINATION [Faint text, possibly "June 8, 1956"]		PLACE OF EXAMINATION [Faint text, possibly "Home"]		TIME OF EXAMINATION [Faint text, possibly "10:00 AM"]		SIGNATURE OF MEDICAL EXAMINER [Faint signature]	

RECEIVED
 JUN 8 1956
 BUREAU V. S.

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS AISC 1-45 10M

6095 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Indian Head</i>	LENGTH OF STAY (in this place) <i>4 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Nanjemo</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 A Rd Perry Wright Homes</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Marie</i> (Middle) (Last) <i>Gutrick</i>		(Month) <i>June</i> (Day) <i>2</i> (Year) <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Wh.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>6-7-17</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	9. AGE last birthday <i>38</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Rison, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Richard E. Proctor</i>		14. MOTHER'S MAIDEN NAME <i>Jenny E. Simmons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Walter Gutrick, Nanjemoy, Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>4 yrs</i>	
IMMEDIATE CAUSE (A) <i>Cirrhosis of Liver</i>			
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Secondary Anemia SEVERE</i>		<i>4 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1952</i> , to <i>6/1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/1</i> , 19 <i>56</i> , and that death occurred at <i>9:45</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Frank A. Duval</i> M.D.		ADDRESS (Street, city, town, state) <i>Indian Head, Md</i>	
DATE <i>6/2/56</i>		DATE SIGNED <i>6-2-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-5-56</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Ignatius</i>		LOCATION (City, town, or county) (State) <i>Hilltop 87d</i>	
24. REC'D BY REGISTRAR <i>Orley Price</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson and Jenkins</i>	
ADDRESS <i>Wash. D.C.</i>			

100

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

JUN 15 1956

RECEIVED

4/20 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be returned for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6996

CERTIFICATE OF DEATH

06086

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lafayette Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Therm. Hosp Md</u>		d. STREET ADDRESS <u>Spring Hill</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph RALPH HINDLE</u>		4. DATE OF DEATH Month Day Year <u>6 21 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-56</u>
9. AGE (In years last birthday) yrs. <u>30</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RALPH Joseph HINDLE</u>		14. MOTHER'S MAIDEN NAME <u>Mamie ELIZABETH LEWIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FATHER</u> Address <u>Sp. Hill Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>762.5 A + Lect + ASIS</u> DUE TO (b) <u>PREMATURITY 31 wks wt 3 1/2 lbs.</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-21-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23</u> , 19 <u>56</u> to <u>6-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-20</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		DATE SIGNED <u>6-21-56</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sand Tract</u>		22d. LOCATION (City, town, or county) (State) <u>Lafayette, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph J. Hindle</u> ADDRESS <u>Arboretum Funeral</u>		24a. REC'D BY REGISTRAR DATE <u>6/23/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia H. Posner</u>			

2066203XV2

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ladysburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ladysburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy Men Hosp Ladysburg</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Bonnie Lou JAMESON</i>		4. DATE OF DEATH <i>6 13 1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-28-56</i>
9. AGE (In years last birthday) yrs. <i>16</i>		IF UNDER 1 YEAR <i>16</i> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Francis W. Jameson</i>		14. MOTHER'S MAIDEN NAME <i>ELLA MAC ADAMS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Francis W. Jameson (FATHER)</i>		Address	
18. CAUSE OF DEATH: [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>761.5 ATLECTASIS</i> DUE TO (b) <i>PREMATURITY, EDC. 8-20-56</i> DUE TO (c) <i>PLACENTA PRÆVIA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-13-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-28</i> , 19 <i>56</i> , to <i>6-13</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6-12</i> , 19 <i>56</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>6-13-56</i>			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.			
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/14/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Brownstown Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home Waldorf</i>		24a. REC'D BY REGISTRAR <i>DATE 6-18-56</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. F. Mills Perry</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

*Charles
Johnston
10 days*

*Francis W. Thompson
2-28-25*

13 25

*Francis W. Thompson
Francis W. Thompson (Francis)*

*Attest:
Francis W. Thompson
2-28-25*

X

BUREAU V. S.

2-28-25

RECEIVED
JUN 18 1925
6-13-25

Francis W. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Potomac River Bridge		1313 N. Broadway		3V01-4			
3. NAME OF DECEASED (Type or print) First HELEN Middle DOLORES Last JOHNSON				4. DATE OF DEATH Month June Day 1 Year 1956			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 2, 1937	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 1 Days 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, area if retired) DOMESTIC PRIVATE FAMILY		10b. KIND OF BUSINESS OR INDUSTRY M.D.		11. BIRTHPLACE (State or foreign country) U. S. A.			
13. FATHER'S NAME Wm. Johnson			14. MOTHER'S MAIDEN NAME MARIE HOWARD				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Wm. Johnson-1313 N. BROADWAY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive left thoracic hemorrhage DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in chest					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Not a natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED June 4, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 6/6/56		22b. DATE THEREOF 6/6/56		22c. NAME OF CEMETERY OR CREMATORY GOUGH'S			
22d. LOCATION (City, town, or county) COCKEYSVILLE, MD.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Schatman</i>			24a. REC'D BY REGISTRAR JUN 6 1956				
ADDRESS 1701 N. Callof			24b. REGISTRAR'S SIGNATURE <i>A. H. Hedrick</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FOR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-15-1984

100.00

1518 J. E. Garvey

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negative field effects

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BUREAU V. S.

3561 9 Nnr

RECEIVED

6999 **CERTIFICATE OF DEATH**Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place) <u>4 HOURS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HUGHESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>COUNTY JAIL</u>				STREET ADDRESS (If rural give location) <u>Rte. #5</u>			
3. NAME OF DECEASED (Type or Print) <u>JEROME LYON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 15 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE US</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Sept 2 1912</u>		9. AGE last birthday <u>43</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Guy Lyon</u>				14. MOTHER'S MAIDEN NAME <u>Leigiana Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Mrs Otis Cowick, Marlboro Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MYOCARDIAL DEGENERATION (CARDIAC FAILURE)</u>						<u>30 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CHRONIC MALNUTRITION</u>						<u>1 MONTH</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JULY 1947</u>, to <u>JUNE 15, 1956</u>, that I last saw the deceased alive on <u>JUNE 15, 1956</u>, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.		DATE THEREOF <u>6-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Box #65 Hughesville Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mrs. F. Mills Posey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	
DATE <u>6-19-56</u>							

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

DATE: 10/10/2001

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplat</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplat</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>First</i> <i>Eus</i> <i>Middle</i> <i>Matthews</i> <i>Last</i>		4. DATE OF DEATH <i>June 26 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 5, 1908</i>
9. AGE (In years last birthday) <i>47</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Matthews</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Sweetney</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-16-5585</i>	
17. INFORMANT <i>Mary Matthews Laplat</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Decomposition</i> (c) <i>Chronic myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 26, 1956</i> to <i>June 26, 1956</i> , that I last saw the deceased alive on <i>6/26/56</i> , 1956, and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William J. Kury</i> M.D.		ADDRESS (Street, city or town, state) <i>Laplat</i> DATE SIGNED <i>6/28/56</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM J. KURY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6/29/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>	22d. LOCATION (City, town, or county) (State) <i>Laplat MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Laplat</i> ADDRESS		24a. REC'D BY REGISTRAR <i>June 29, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>John H. Boney</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 8

7 2 1956

RECEIVED

6101

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY 55X-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b 1 month ?		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First James Middle L. Last Mc Dougall			4. DATE OF DEATH Month June Day 17 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1899	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME Le Roy Mc Dougall			14. MOTHER'S MAIDEN NAME Josephine Matchman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) Address Nozorene Mc Dougall	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH 7 days 5 years 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) La Plata, Maryland.	
21. I certify that I attended the deceased from June 11 , 19 56 , to June 17 , 19 56 , that I last saw the deceased alive on June 17 , 19 56 , and that death occurred at 2 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE William J. Kurz		ADDRESS (Street, city or town, state) La Plata, Maryland.		DATE SIGNED 6-18-'56	
PHYSICIAN'S NAME (Type) William J. Kurz, M. D.		La Plata, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Ship		22b. DATE THEREOF 6-18-'56		22c. NAME OF CEMETERY OR CREMATORY Calvary	
23. FUNERAL DIRECTOR'S SIGNATURE Richard E. Mc LaPlata		ADDRESS La Plata, Md		24a. REC'D BY REGISTRAR 6/20/56	
				24b. REGISTRAR'S SIGNATURE Julia H. Carey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06092

6102

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Chas.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician Memorial</u>				STREET ADDRESS (If rural give location) <u>Tompkinsville</u>			
3. NAME OF DECEASED (Type or Print) <u>PAUL</u> (First) <u>MILLARD</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmmer</u>		11. BIRTHPLACE (State or foreign country) <u>UNK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>David Millard</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Celestine Tenant</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Respiratory failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Colic</u>	
ANTECEDENT CAUSE(S) DUE TO <u>CUA</u>						<u>9 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arterio sclerotic heart disease with hypertension</u>						<u>over 1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>5 March, 1955</u> , to <u>1 June, 1956</u> , that I last saw the deceased alive on <u>June 1, 1956</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. Wooddy</u>				ADDRESS (Street, city, town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>June 5, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
24. REC'D BY REGISTRAR <u>6/6/56</u>		REGISTRAR'S SIGNATURE <u>Mrs. F. Halla Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>			
DATE				ADDRESS <u>Walters, Md.</u>			

10005

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. One, 1900

1. NAME OF DECEASED

2. SEX
3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

BUREAU V. S.

JUN 6 1956

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON THE DAY FOLLOWING THAT OF THE DEATH.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06093

CERTIFICATE OF DEATH

6103

Reg. Dist. No. 1A

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Old.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>New Smy</i>		<i>15 minutes</i>		TOWN <i>New Smy</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural, give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>James Edward Posey</i>				<i>June 2 19 56</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>Col.</i>	<i>Single</i>	<i>6-2-56</i>	<i>15 yrs.</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Infant</i>				<i>New Smy. Old</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Andrew Posey</i>				<i>Ruth Irene Gutrick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>				<i>Jas A. Posey, New Smy. Old</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<i>Primaturity</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)				<i>(Expected Delivery Date was 8/15/56)</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/2</i>, 19<i>56</i>, to <i>6/2</i>, 19<i>56</i>, that I last saw the deceased alive on <i>6/2</i>, 19<i>56</i>, and that death occurred at <i>1P</i> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Frank H. Posey</i>				<i>Indian Head, Old</i>		<i>6-2-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6-3-56</i>		<i>St. Hope Cemetery</i>		<i>Indsides, Old</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>June 3/1956</i>		<i>J. O. Thompson</i>		<i>William A. Posey</i>		<i>New Smy. Old</i>	

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CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL HISTORY

11. OCCUPATION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

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BUREAU V. 2

JUN 5 1956

RECEIVED

6104

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laplaton</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phy Mem Hosp</i>		d. STREET ADDRESS <i>Bel Alton Md.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>ANNIE</i> Middle <i>ROSIE</i> Last <i>ROSE</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 8 1891</i>
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>4</i>	IF UNDER 24 HRS. Hours <i>15</i> Min. <i>30</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chas Co</i>	
11. BIRTHPLACE (State or foreign country) <i>Chas Co</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Daniel Roseier</i>		14. MOTHER'S MAIDEN NAME <i>Thannie Power</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Harry Roseier</i>		Address <i>Bel Alton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>4 Days</i> <i>15 yrs</i> <i>30 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-11-56</i> , 19 <i>56</i> , to <i>6-14-56</i> , that I last saw the deceased alive on <i>6-14-56</i> , 19 <i>56</i> , and that death occurred at <i>5:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Johnson</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>6-14-56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Ignatious</i>	22d. LOCATION (City, town, or county) (State) <i>Bel Alton Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Michael Inc La Plata Md</i>		24a. REC'D BY REGISTRAR <i>6/20/56</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Julia Roseier</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 8

JUN 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Physicians Memorial</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ridgley</i> Middle <i>Scott</i> Last <i>Scott</i>		4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>1956</i>		5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-28-1881</i>		9. AGE (In years, last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>UNK</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Scott</i>				14. MOTHER'S MAIDEN NAME <i>Louise Whalen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Annie Scott Port Tobacco, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic C.A. Lung</i> <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ca. Prostate</i> DUE TO (c) <i>Ca. Prostate</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1956</i> <i>6-3-53</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-3-56</i> , to <i>6-28-56</i> , that I last saw the deceased alive on <i>6-28-56</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>La Plata Md.</i> DATE SIGNED <i>6-24-56</i>							
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.				PHYSICIAN'S NAME (Type) <i>E. J. EDELEN M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7-2-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ST CATHERINES Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Mc Conchie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>				ADDRESS <i>Wardone</i>		24a. REC'D BY REGISTRAR <i>2</i> 1956	
				24b. REGISTRAR'S SIGNATURE <i>Julia H. Pray</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>July 1, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
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19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06096

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel St Clair		4. DATE OF DEATH June 11, 1956 19	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY FARMING	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James St Clair		14. MOTHER'S MAIDEN NAME Catherine Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. m	
17. INFORMANT Wilson Penn		Address Hughesville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X Cerebral hemorrhage DUE TO (b) Fract. Skull DUE TO (c) Hit by auto CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6-11-56 6-11-56 6-11-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Communicated from left thigh & foot			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Hit by auto & pedestrian	
20c. TIME OF INJURY Month, Day, Year 2 p.m. 6-11-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Beltsville (County) Beltsville (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-56	
22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) New York (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE HUNT Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR DATE 6-18-56	
		24b. REGISTRAR'S SIGNATURE Mrs. F. Wilcox	

STATE OF MONTANA
DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6-11-05
6-11-05
6-11-05

George
H. H. H.
H. H. H.

George H. H.
H. H. H.
H. H. H.

BUREAU V. S.
H. H. H.

JUN 18 1956

RECEIVED
JUN 18 1956

F. J. EDELEN II
H. H. H.
H. H. H.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06097

6107 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>82X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Montgomery Center</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby Gerb Stevens</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 13 19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>		8. DATE OF BIRTH <u>June 12, 1956</u>	
				9. AGE last birthday <u>Newborn</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>5 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Madeline Stevens same as 12</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
773.5 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>respiratory failure</u> <u>Prematurity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>5 hrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-12, 1956</u> , to <u>early</u> , 19....., that I last saw the deceased alive on <u>6-12, 1956</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>La Plata, Maryland</u>			
DATE <u>6-13-56</u>				DATE SIGNED <u>6-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/13/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>La Plata MD</u>	
24. REC'D BY REGISTRAR <u>6-18-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. P. Dilleden</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Heart Funeral Home</u>		ADDRESS <u>North + Ryan</u>	

2066161XVO

CERTIFICATE OF DEATH

Reg. No. 112

1. Name of deceased (Print or write full name)

2. Date of death

3. Place of death (Print or write full name of place)

4. Cause of death (Print or write full name of cause)

5. Nature of disease (Print or write full name of disease)

6. Duration of disease (Print or write full name of duration)

7. Name of attending physician (Print or write full name)

8. Name of medical examiner (Print or write full name)

9. Name of coroner (Print or write full name)

10. Name of registrar (Print or write full name)

11. Name of funeral director (Print or write full name)

12. Name of cemetery (Print or write full name)

13. Name of burial place (Print or write full name)

14. Name of interment place (Print or write full name)

15. Name of final resting place (Print or write full name)

16. Name of informant (Print or write full name)

17. Name of informant (Print or write full name)

18. Name of informant (Print or write full name)

19. Name of informant (Print or write full name)

20. Name of informant (Print or write full name)

21. Name of informant (Print or write full name)

22. Name of informant (Print or write full name)

23. Name of informant (Print or write full name)

24. Name of informant (Print or write full name)

25. Name of informant (Print or write full name)

26. Name of informant (Print or write full name)

27. Name of informant (Print or write full name)

28. Name of informant (Print or write full name)

BUREAU V. S.

JUN 18 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06098

Reg. Dist. No. 105

6108

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE Ohio b. COUNTY Columbiana			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbus 72 X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS 610 City Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Phoebe Middle Ann Last Stevenson				4. DATE OF DEATH Month 6 Day 8 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1871		9. AGE (in years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 8 Days 8	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Susan Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Caroline Bechel		Address Columbus, Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumptive Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William J. Kurz M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/11/56	
EXAMINER'S NAME (Type) William J. Kurz, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-'56		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Columbus Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Avon's Funeral Home				ADDRESS Waldorf, Md		24a. REC'D BY REGISTRAR DATE 6-12-56	
				24b. REGISTRAR'S SIGNATURE W. L. Monroe			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. Johnson		Male		38		White		May 3, 1956		Home	
Residence		Occupation		Cause of Death		Manner of Death		Medical History		Other Notes	
1234 Main St., Baltimore, Md.		Police Officer		Myocardial Infarction		Natural		Hypertension, Atherosclerosis			
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 5

JUN 12 1956

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Handwritten notes and signatures at the bottom of the page.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6109 CERTIFICATE OF DEATH

06099

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>La Plata</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Belt Alton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phyl Memorial Hosp</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>MARY ALICE THOMPSON</i>				4. DATE OF DEATH (Month) <i>6</i> (Day) <i>23</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct 25, 1923</i>	9. AGE last birthday <i>32</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Samuel Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Marjorie Crooney</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Samuel B. Thompson Belt Alton md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <i>Congestive Heart Failure</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Coronary Vascular Disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6-19-56</i> to <i>6-23-56</i> , that I last saw the deceased alive on <i>6-23-56</i> and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>E. J. Delaney</i>				ADDRESS (Street, city, town, state) <i>La Plata Md</i>		DATE SIGNED <i>6-23-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>6/26/56</i>	NAME OF CEMETERY OR CREMATORY <i>St Ignace</i>		LOCATION (City, town, or county) <i>Belt Alton md</i>		(State)	
24. REC'D BY REGISTRAR DATE <i>JUN 28 1956</i>	REGISTRAR'S SIGNATURE <i>Mrs. L. Hiller</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>		ADDRESS <i>unbloff rd</i>		

CERTIFICATE OF DEATH

Form No. 10

A. FULL NAME OF DECEASED

B. PLACE OF DEATH

C. SEX

D. AGE

E. DATE OF DEATH

F. TIME OF DEATH

G. PLACE OF BIRTH

H. OCCUPATION

I. CAUSE OF DEATH

J. MEDICAL OPINION

BUREAU V. 1

JUN 28 1956

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DEPT. OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE MEDICAL EXAMINER WHO EXAMINES THE BODY. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G199 7-9-56 et

CERTIFICATE OF DEATH

6110

06100
Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA Plata</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>LA Plata</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>H</i> Last <i>WOODLAND</i>				4. DATE OF DEATH Month <i>6</i> Day <i>24</i> Year <i>1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 18, 1869</i>	9. AGE (In years last birthday) <i>86</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Charles Co MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James C. Woodland</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sidney Woodland La Plata</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular renal</i> <i>442X</i> DUE TO (b) <i>disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Gen. Art Sclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-18-56</i> , to <i>6-24-56</i> , that I last saw the deceased alive on <i>6-22-56</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F. J. Edelex</i> M.D.				ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>		DATE SIGNED <i>6-24-56</i>	
PHYSICIAN'S NAME (Type) <i>F. J. EDELEN M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-28-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph</i>		22d. LOCATION (City, town, or county) (State) <i>Pomfret Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson & Jenkins</i> ADDRESS <i>1702 12th St NW</i>				24a. REC'D BY REGISTRAR <i>6/28/56</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Hargy</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>James C. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 27, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
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58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
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100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

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